AUTOMATED MEDICAL BOARD REPORT COVER SHEET INTERNAL MEDICINE OUTPATIENT BO

FROM: NAVAL HOSPITAL,CAMP LEJEUNE,NC NAME: KIMBLE, RONNIE L
TO: PEB ARLINGTON, VA DUTY STATION: 3/2, 2ND MARDIV
VIA: MEDICAL BOARD DIVISION SSN: - - SEX: MALE RACE: C
LENGTH OF SERVICE: 3 YR 11 MON GRADE/RANK SERVICE DOB: 72.01.17
RPTUIC->68093 DUTYUIC->12130 PSDUIC->12130 CPL USMC MTO:
CAUSE OF INJURY: OTHER EXTERNAL CAUSE EAOS: 97.04.06
ENTRANCE PHYSICAL EXAMINATIONS:
ADMITTED TO SICK LIST: NO DATE OF DISPOSTION: N/A LOD REQUIRED: NO
DATE OF BOARD: 18 March 1997 DISCIPLINARY ACTION PENDING: NO

	ICD-9-CM	DIAGNOSIS	EPTE(ORIGIN)
PRIMARY:	7811	HYPERSOMNOLENCE WITH EXCESSICE DAYTIME SLEEPINESS	3
SECOND:			
THIRD:			
FOURTH:			
FIFTH:			
SIXTH:			

A 19

INDICATED DISPOSITION: REFER TO PHYSICAL EVALUATION BOARD
LIMITED DUTY EXPIRES ON: N/A LIMITATIONS ARE:
WITH

BOARD MEMBERS — SIGNATURE

SENIOR MEMBER: S. REED, CDR MC USN — Sandra L Reed MD

JUNIOR MEMBER: E. CZANDER**, LT MC USNR — E C Czander

ENCLOSURES:

X	SIGNED NAVMED 6100/2		MEMBERS'S REBUTTAL		LOD INVESTIGATI
	SIGNED NAVMED 6100/3	X	COPY OF HEALTH RECORD		CLINICAL RECORD
X	PREVIOUS BOARD	X	SF 88, SF 93	X	DD FORM 2697

ACTION: MEMBER SENT TO TO AWAIT FINDINGS
APPROVED: YES/NO ADMINISTRATIVE INVOLUNTARY SEPARATION IS/IS NOT PENDING.
DATE CONVENING AUTHORITY SIGNATURE
S.R.MCCLELLAND,BY DIRECTI, CAPT MC USN

MEMO ENDORSEMENT UPON REEVALUATION: MEMBER EXAMINED THIS DATE. THE RESULTS AND FINDINGS ARE: _____

MEMBER COUNSELED THIS DATE OF THE FINDING OF FIT FOR FULL DUTY:
DATE SIGNATURE GRADE/CORPS/SERVICE

EXAM PHYSICIAN:

MEMBER:

HEAD OF DEPT:

MEMBER TRANSFERRED TO _____
AWAITING FINAL ACTION

NAVAL HOSPITAL, CAMP LEJEUNE, NORTH CAROLINA 28547-0100

154
D/T:03-18/19-97

Subj: KIMBLE, RONNIE L., CPL, , USMC

This 24-year-old, Caucasian male, Corporal, United States Marine Corps, with 03 years and 11 months active duty, was evaluated in the Neurology Clinic, Naval Hospital, Camp Lejeune, North Carolina on 18 March 1997 for HYPERSOMNOLENCE.

Attention is invited to the report of the previous Medical Board dated 15 May 1996 from Naval Hospital, Camp Lejeune, North Carolina with the diagnosis of HYPERSOMNOLENCE, recommending six months limited duty.

The patient is a twenty-four year old right handed male evaluated in the Neurology Clinic for hypersomnolence. The patient states that this has been progressively worsening over many years. He states he falls asleep many times during the day and has occurred once while driving. It also can occur while standing. He knows when he is about to fall asleep. Caffeine has been of no help. He has no trouble falling asleep at night or staying asleep. His wife has noted him sitting up while sleeping and he states he slept walked as a child; no noted sleep walking as an adult. He goes to sleep around 10:00 p.m. and wakes up at 7:00 a.m. He takes 0-1 naps per day. He denies any headaches, no vision changes, no diplopia, no dysarthria, dysphagia, weakness or numbness, no loss of consciousness, head trauma or seizure activity, no enuresis, tongue bite or muscle soreness upon awakening. The patient has been evaluated by a sleep specialist, Dr. DeBeck, and was diagnosed as possibly being a long sleeper. He's had a polysomnogram with multiple sleep latency tests back in 1995 which was determined to be normal. He's also had further work-up including a psychiatric consult which showed no abnormalities, an MRI of the head in May of 1996 which was normal and this was done with gadolinium. He had a Chem-18, CBC, sedimentation rate, Monospot, angiotensin converting enzyme level, RPR, MHA, urinalysis and urine drug screen which were all normal. He was tried on a trial of Zoloft 50 mg PO q day without any evidence of help and he underwent a second polysomnogram multiple sleep latency test on 22 January 1997. The patient had 34 respiratory events averaging about 4 per hour with a minimal oxygen saturation at 89%. Multiple sleep latency tests showed a mean sleep latency of 10.4 minutes and no sleep onset REM over 4 naps. He was diagnosed as having primary snoring and no evidence of significant obstructive sleep apnea, narcolepsy or pathologic sleepiness. He was also seen by an allergist at Portsmouth and there was no determined cause of his hypersomnolence secondary to allergies. He had been evaluated by Ear, Nose and Throat and had a septoplasty done in September of 1996. This did not help him in terms of his sleepiness during the day. The patient also denied any sleep paralysis or hypnagogic and hypnopompic hallucinations. The patient also denied any anhedonia but he did have the stress of his wife having a miscarriage in 1996.

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Past medical history; nonsignificant. Medications; none. Allergies; none. Social history; the patient is married, he has no children, he works in the Base Chaplain Office. He dips about one can every 2 days and rarely drinks. He denies any drug use. Family history; his brother has similar problems. Review of systems is otherwise negative.

Physical exam; the patient is a well-developed, well-nourished white male in no apparent distress with blood pressure of 115/64, pulse of 68, respirations of 16, temperature of 98.9, height of 72 inches and weight of 175 pounds. He is alert and oriented x 3. His attention to months in reverse is normal. Naming, comprehension, repetition and fluency are all normal. Visuospatial skills are normal. Funduscopy exam shows sharp discs bilaterally. Pupils are equally round and reactive to light and accommodation are intact. He has full visual fields. His face is symmetrical. Tongue and palate are midline. He has normal facial sensation, normal opticokinetic nystagmus but he does have breakdown of smooth pursuit. He has 5 out of 5 strength throughout in all four extremities, no pronator drift, normal fine finger movements and finger-to-nose testing. His gait and tandem walking are normal. He has normal vibration and temperature and pinprick sensation. He has 2+ deep tendon reflexes, symmetrically and downgoing plantar responses bilaterally.

Assessment is hypersomnolence with excessive daytime sleepiness. The patient has had two polysomnogram multiple sleep latency tests which did not show any evidence of definite pathology. There is no definite evidence of significant obstructive sleep apnea or narcolepsy. However this has been interfering with his work and he did at one point fall asleep while driving. The plan is to (1) stop tobacco use; (2) increase exercise to at least 3 x per week and (3) to get in contact with the Sleep Disorder Association of America.

FINAL DIAGNOSIS:

HYPERSOMNOLENCE WITH EXCESSIVE DAYTIME SLEEPINESS

It is therefore the opinion of the Medical Board that the above diagnosis is correct. The Board concludes that this condition limits and or deters the patient's ability to satisfactorily fulfill the duties of an active duty member. The Board therefore refers the patient's case to the Physical Evaluation Board for final disposition.

The patient has been informed of the contents of Medical Board's report and does/does not desire to submit a statement in rebuttal.